Hello, everyone. Thank you for joining today's Participation Criteria for Year 2 of the Quality Payment Program Webinar. The purpose of this webinar is to discuss the criteria used to determine inclusion in the Merit-based Incentive Payment System and Advanced Alternative Payment Models for the Quality Payment Program. Now I will turn the call over to Adam Richards, Health Insurance Specialist at the Division of ESRD, Population and Community Health and Quality Improvement and Innovation Group with the Center for Clinical Standards and Quality at CMS.

Okay, great. Thank you. And hello, everyone. Thank you, again, for joining us today. I do want to take the opportunity to welcome you all to today's discussion on the Participation Criteria for Year 2 of the Quality Payment Program. There seems to be some excitement, quite a bit of interest, and a general eagerness to learn about our Year 2 policies. I will say this is not the first, nor will it be the last event that we host to discuss the various aspects of the 2018 performance year. We know we have a number of ideas on areas that we may need to cover, but we're also interested in hearing your feedback. So if there are certain topics that interest you, please let us know. Feel free to even use the chat feature, which we'll be monitoring throughout the event today. I do just want to quickly remind you all that you can stay up to date on our upcoming educational webinars and events by signing up for the Quality Payment listserv on qpp.cms.gov. We've made it as least burdensome as possible. You just visit the site, scroll down, enter your e-mail, and hit "Subscribe" -- four quick steps. So, moving into our presentation today -- I'm going to jump to Slide 3. As you can see, this is a fairly robust webinar. We will discuss the participation criteria for both the Merit-based Incentive Payment System and Advanced Alternative Payment Model Tracks of the Quality Payment Program. For MIPS, our plan is to focus on aspects such as the low-volume threshold, individual and group participation, special status and what it means to have a special status, and a few other areas. For the APM side, we're going to talk about Advanced APMs at a high level, the criteria for how to become a qualifying APM participant under an Advanced APM. We'll focus in on the All-Payer Combination Option, and then wrap up with the discussion about MIPS APMs, specifically around how the low-volume threshold applies to those MIPS APMs, because this is certainly one question that we receive quite frequently. We'll also walk each of you through how to check your participation status using our website and where you can find help and support, and, of course, we'll take some questions at the end as time allows. So, on the next slide, at a high level, we are required by law -- really from MACRA -- to implement the Quality Payment Program, which contains both MIPS and Advanced APM tracks. As I mentioned, we'll cover both of those tracks today. Policy aside, some themes that I hope you'll notice today as we progress through our discussion are flexibility – especially in the ways in which a clinician participates, a continued transition, recognizing that we have made relatively modest changes to some of our policies to continue to allow clinicians to familiarize themselves with the program and prepare for future program years, and also burden reduction, which is one of our top priorities here at CMS -- really across all of our programs. So, keep those themes in mind as we kind of move forward, and with that, I'm going to turn it over to my colleague, Molly MacHarris, the MIPS Program Lead, to talk about the Participation Criteria for MIPS. So, Molly.

Thank you so much, Adam, and thank you, everyone, again, for joining us here today. I'm going to go ahead and jump into Slide 6. So just as a brief

refresher, the Merit-based Incentive Payment System combined three legacy programs into one single program. So prior to MACRA and the Quality Payment Program and prior to MIPS, there were three programs that clinicians had to participate in. Those were the Physician Quality Reporting System, the Physician Value-Based Modifier, and the Medicare EHR Incentive Program for Eligible Professionals. Those three programs have since ended, and now we have a cohesive program called MIPS, and if you jump to Slide 7, you can see that under MIPS, what we do is we assess performance on clinicians under four performance categories. So the four performance categories are Quality, Cost, Improvement Activities, and Promoting Interoperability. The first performance category, Quality, that deals with Quality Measurement, so similar to what clinicians would have experienced under the PQRS Program. The Cost Performance Category deals with cost measurement and resource use. So similar to what folks would have experienced under the value modifier. The Promoting Interoperability Performance Category, which was previously called the Advancing Care Information Performance Category, deals with the usage of certified EHR technology similar to the Meaningful Use Program, and then the Improvement Activities Performance Category, this was new under MACRA, and this deals with practice-level improvements that clinicians and practices can take. You'll note that all four of these performance categories have numbers associated with them, and all of those four numbers sum up to 100 points. That becomes important because what we do is we measure clinicians' performance on these four categories, and we assign to clinicians something called a final score, and that final score can range from zero to 100 points. Depending upon what the clinician's final score is in relation to something called a performance threshold will determine whether or not clinicians receive a positive adjustment -- so more money, a negative adjustment, so a reduction in your physician fee schedule charges, or a neutral adjustment, which would mean no payment impact. The performance threshold for the second year is 15, so we really want to encourage all clinicians to have their final score at or above 15 points. And moving on to Slide 8, as I just mentioned, we have recently changed the name of the Advancing Care Information Performance Category to Promoting Interoperability. We recently released the In-Patient Prospective Payment System, IPPS and Long-Term Care Hospital Prospective Payment System proposed rule. While the proposed changes in the rule are important, I do highly recommend reviewing our proposal, and I'm bringing this to your attention because we are addressing the meaningful-use element that cuts across many programs. We are rethinking the concept of Meaningful Use to focus on Interoperability. We want to make the program more flexible and less burdensome, emphasize measures that require the exchange of information between patients and providers, and incentivize providers to make it easier for patients to get their record. We also want to get to a state where all clinicians are using 2015 edition certified EHR technology by 2019, and the built-in API, or Application Programming Interface functionality to improve the flow of information between providers and patient. Because of this, we're changing the name of Meaningful Use or Advancing Care to Promoting Interoperability. So what this means is that, moving forward, the Advancing Care Information Performance Category will be referred to as Promoting Interoperability. You will begin to start seeing this name change in all of our MIPS and APM educational resources and communications moving forward, so please take this opportunity to familiarize yourself with this new interoperability effort. We also have more information on the proposed rule, as well as press releases and fact sheets on our website at cms.gov. So let's go ahead and jump into Slide 9 and 10, where I will start going over some of the participation basics. So on Slide 10, in Year 2 of the program, eligible clinicians can participate in MIPS in four ways. The first is as an

individual, the second is as a group, the third is as a virtual group, and then the last option is participating as an APM. We define individuals as a unique TIN/NPI combination, so a unique Tax Identification Number and unique National Provider Identifier. We define "Group" as a unique TIN with two or more NPIs that have reassigned our billing rights over to that group. We also newly offered in the second year of the program the opportunity for clinicians to form virtual groups. This is an option where small practices of 10 or fewer, or solo practitioners can virtually come together to form a group, and then we also have APM, which I won't get into too much detail on, but my colleague Corey will be going over that a little bit later. So, let's move on to Slides 11 and 12 to start breaking down how you can participate. So, on Slide 12, the types of eligible clinician. So, there's no change in who is eligible to participate in the second year. So, the same types of clinicians who are eligible in the first year are Physicians, Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists can still participate in the second year. I do want to note that when we talk about physicians under the Quality Payment Program, we don't just mean MDs and D.O.s. We also include chiropractors, dentists and podiatrists and optometrists in that definition. Moving on to Slide 13. So, our change to our Low-Volume Threshold exclusion. So, we have a number of exclusions under MIPS at the program level. The one that we talk about the most is the Low-Volume Threshold. So, what the Low-Volume Threshold does is clinicians who fall below the Low-Volume Threshold, they would be excluded. Clinicians who fall above the Low-Volume Threshold are eligible. So we've increased the Low-Volume Threshold from the first to the second year. We've increased it to $90,000 in allowed charges and 200 patients. So, if a clinician fills greater than $90,000 in allowed charges, and if they see 200 or more patients, then they are eligible to participate in the program. There are also terms called "special statuses," which I will talk through in a little bit more detail in a few upcoming slides, but I do just want to be really clear that for clinicians who exceed the Low-Volume Threshold, you are eligible to participate in MIPS, and we will talk about in more detail ways that you can determine whether or not you are eligible based off of some resources that we have on our website. So an example of how we perform this Low-Volume Threshold check is on Slide 14. So, first what we do is we determine whether clinicians meet the definition of being eligible, so whether or not you're a Physician, Physician Assistant, et cetera. Then we perform two snapshot looks to determine whether or not you are eligible based off of the Low-Volume Threshold of $90,000 and 200 patients. The first look that we take is historical, and so we look at your claim, which run from September through August, to make our initial determination. And what we do there is we determine whether or not you fall above or below the Low-Volume Threshold and any special statuses that you have. If you are determined to be exempt during the initial look -- so if you fall below the Low-Volume Threshold – you will remain excluded in the second look, as well. And then we have our second determination period, which also runs from September through August, to identify any additional clinician who would not have been captured in our first look. So, again, if you're included in the first determination period, you could be reclassified as excluded if your charges significantly change from the first look to the second look, but, again, if you were initially found to be excluded in the first look, that will carry over into our second determination period.

Moving on to Slide 15. One of the other common questions that we get is what clinicians have to do if they're associated with multiple practices. So, remember that when we talk about MIPS, we classify clinicians based off of their unique TINS or unique Tax Identification Number and their unique NPI

status. So, for clinicians who may work at multiple practices, and they may have multiple TINs, we determine whether or not someone is eligible and able to participate under each of those TINs. So, there could be the potential that if you are a clinician and if you practice at multiple practices for multiple organizations, you may be eligible in one of those organizations, but not in all. Moving on to Slide 16. So just addressing the performance threshold and the payment adjustments. So, I touched on this a little bit earlier, but just to highlight this again, because this is how we actually determine someone's payment-adjustment percentage, so that comes down to money. The changes that we made for the second year is we've increased the performance threshold from three points to 15 points. For clinicians whose final scores are above 15 points, upwards to 69.99 points, they would get a positive adjustment, which could span between zero up to 5%, and then for clinicians whose performance threshold is at or above 70 points, they would be eligible for an exceptional performance bonus, and then for clinicians whose final scores fall below 15 points, they would get a negative payment adjustment, and that can scale depending upon what your specific final score is. Moving on to Slide 17So some of the additional exclusion criteria that we have. So I've already talked through the middle one, the Low-Volume Threshold. The other exclusion criteria we have for MIPS is if a clinician becomes newly enrolled in Medicare during the performance period. So this would be the first time that a clinician enrolled in our PECOS System. If they do that during calendar year '18, they would not be required to participate in MIPS for this year. They would, however, be eligible and able to participate in the following year. We also have an exclusion for clinicians who significantly participate in Advanced APM. They have the ability to be excluded from MIPS, as well. Let's move on to Slide 18 and 19 for how you can participate at a group level. So, one of the questions that we also get commonly asked is, for the Low-Volume Threshold for $90,000 and allowed charges and 200 Medicare Part B beneficiaries, how does that get applied at the group level if your organization decides to participate as a group? So, the answer to that is, yes, we do apply the Low-Volume Threshold at the level that clinicians participate at. So if you participate as an individual, we would make the Low-Volume Threshold assessment at the individual level. If you participate as a group, we would look for your group to meet or exceed the Low-Volume Threshold. Moving on to Slide 20 for an example of that scenario. So, as you can see, on the left-hand side of the slide, so for individual, if you look at Dr. "A," he billed $250,000 in allowed charges and saw 210 patients. So Dr. "A" is included and eligible for MIPS. Dr. "B," she billed $100,000 in allowed charges, but only saw 80 patients. So she would be exempt from MIPS. And then we have our third clinician, our Nurse Practitioner, who billed $50,000 in allowed charges and saw 40 patients. So he would also be exempt from MIPS if all three of these clinicians decide to participate individually. However, if the organization decides to participate as a group, we would sum all of the allowed charges together and the patients together, and as you can see, on the right-hand side of the slide, that would mean that participation at the group level is possible. So, one of the other questions that we get asked is, what are the advantages of doing this? Why would someone want to participate at the group level if they could be excluded as an individual? And it's really a decision that your practice should make as these are conversations that your organization should have. For those practices who decide to participate as a group, they would have the ability to potentially earn a positive payment adjustment, so they could earn more money. For clinicians who decide to participate individually, and if they're excluded, those clinicians, again, would not have to participate, but those clinicians who are eligible as individuals, again, we do highly encourage those folks to participate in the

program so they can avoid a negative payment adjustment. So let's move on to Slides 21 and 22 to talk through how to participate as a virtual group. So, as I mentioned earlier, virtual group is a new option that we have available in the second year of the program where clinicians can virtually come together no matter their specialty or location to participate in MIPS. To be eligible to join a virtual group, the clinicians would either need to be a solo practitioner or a group of 10 or fewer eligible clinicians. On Slide 23, a few other pieces of information you should know about virtual groups: Generally, we treat virtual groups as groups, meaning all of the policy options and participation options that we have available for groups are available for virtual groups. All clinicians that are part of a TIN that forms the virtual group are required to participate as part of a virtual group. We also do require virtual groups to aggregate their data across the virtual group for each of the performance categories, and virtual groups must make their election to be a virtual group prior to the beginning of the performance period. That is something that's required by law, so we will need clinicians who want to participate to form a virtual group. They will annually have to make their election prior to the beginning of the performance period. So let's move on to Slide 24 and 25 to talk through our special statuses. So, some of the questions that we hear from folks are that they seem to get confused on the difference between our exclusions and our special statuses. So let's try to unpack this for everyone. So, the exclusions that we have, which I already went over, include the Low Volume Threshold, being newly enrolled to Medicare, and then significant participation in an APM. If you meet one of those exclusions, that means that the clinician is entirely excluded from participation in MIPS overall. If a clinician had a special status, that means that they are eligible to participate in the program, but they may have to do something different, or oftentimes a little bit less under some of our performance categories. So the special statuses that we have include being a Non-Patient Facing clinician, being part of a Small Practice, being part of a Rural Practice, being in a practice that is in a Health Professional Shortage Area, or HPSA area, being a Hospital-Based clinician, and being an Ambulatory Surgical Center-based clinician. I will go over what all of these definitions and what these special statuses are in a little bit more detail in a few upcoming slides. But, again, I do want to emphasize that just because a clinician has a special status does not mean that you are exempt from MIPS. You are still eligible and able to participate in MIPS, it just may mean that what you have to do is a little bit different. So, for example, clinicians that are considered to be a Small Practice or Rural Practice or in a HPSA area receive double points under the Improvement Activities performance category. Also, clinicians that are Non-Patient Facing, Hospital-Based, Ambulatory Surgical Center-based, as well as clinicians that are Physician Assistants, Nurse Practitioners, Clinical Nurse Specialists, and Certified Registered Nurse Anesthetists all will receive an automatic reweighting of the Promoting Interoperability performance category. So those 25 points that are normally associated with the Promoting Interoperability performance category are reweighted to the Quality performance category. So let's talk through these in more detail. So, moving on to Slide 26, the Non-Patient Facing criteria. So Non-Patient Facing clinicians, these are generally clinicians that do not have face-to-face interactions with patients. So they could include pathologists, certain types of radiologists, certain types of anesthesiologists, as well as nuclear medicine clinicians. Our definition of Non-Patient Facing has not changed. We still define the Non-Patient Facing clinicians as 100 or fewer patient-facing encounter code, and then grouped if the group has 75% of their NPIs to meet that individual definition. We've also expanded this as a virtual group. Moving on to Slide

27. So, clinicians are considered Hospital-Based if they provide 75% or more of their services in an Inpatient Hospital, On-campus Outpatient Hospital, Emergency Room, or, new for Year 2, an Off-campus Outpatient Hospital. The place-of-service code associated with those statuses are also reflected on Slide 27. So, these Hospital-Based clinicians automatically qualify for an automatic reweighting of the Promoting Interoperability performance category. So, again, those 25 points that are normally associated with Promoting Interoperability get redistributed to Quality, so Quality would now count for 75 points towards the clinician's final score. One important thing to note is if a Hospital-Based clinician decides to report, and if data is submitted, we will score the Promoting Interoperability performance category according to our normal scoring rules. Moving on to Slide 28. So we newly added the Ambulatory Surgical Center-based special status. Clinicians are considered ASC-based if they provide 75% or more of their services in Place of Service Code 24, which is defined as a freestanding facility other than a physician's office where surgical and diagnostic services are provided on an ambulatory basis. Again, ASC-based clinicians automatically qualify for that automatic reweighting of promoting interoperability to quality similar to Hospital-Based clinicians. If an ASC-based clinician decides to submit data to us for promoting interoperability, we will score it accordingly. Moving on to Slide 29 -- just to talk through a few more of our special statuses. So our definition of a Small Practice, that's still defined as a practice with 15 or fewer clinicians. Small Practices in the second year of the program are eligible to receive a Small Practice bonus, and, again, Small Practices receive double points under the Improvement Activities performance category. Then we also have our Rural and HPSA status designation, and those definitions have remained the same, as well. So just a few more slides on MIPS. So let's move on to Slide 31 for a few additional special rules and considerations. So, first, Rural Health Clinics and Federally Qualified Health Centers, there is no change to our policy here, which is that items and services furnished by a MIPS eligible clinician and paid under the RHC or FQHC methodology will not be subject to the MIPS payment adjustments, but eligible clinicians do have the option to voluntarily report, but they would not receive any associated MIPS payments. On Slide 32, our Critical Access Hospitals -- again, no change here from the first year, so for Method I, Critical Access Hospitals, the MIPS payment adjustments apply to the payments made by the MIPS-eligible clinicians, but not to the facility itself. The same is for Method II, where billing rights were not assigned, and scenarios where clinicians participate at a Critical Access Hospital under Method II, and they have reassigned their billing right, the payment adjustment will apply in that specific scenario. And then moving on to Slide 33 for some of the questions that we commonly receive related to employment contracts and certain NPI types -- again, no questions here from what our policies were from Year 1 to Year 2. MIPS does apply to you if the covered professional services that you furnish under the Physician Fee Schedule are billed on your behalf by another entity, such as a hospital or health system, and as long as your TIN meets the Low Volume Threshold criteria. And then for our NPI types, only MIPS-eligible clinicians with an NPI Type 1 are required to participate. NPIs that are Type 2 are not required to participate. Just to note, if you do have both an NPI Type 1 and Type 2, and you exceed the Low Volume Threshold, you would be required to participate under MIPS. So, that's it for me on the MIPS Eligibility and participation basics. So, I'm going to go ahead and turn the presentation over to my colleague, Dr. Corey Henderson. Corey.

Good afternoon, everyone. Thank you for calling in. We're going to talk about Alternative Payment Models, and we're going to focus today on Advanced

APMs, MIPS APMs, and we will also discuss the All-Payer and Other Payer Policies. So, before we begin, I'm going to go to Slide 35 here. We're going to talk about the Alternative Payment Models and just a refresher on some key terms that you should know: APM Entity. The APM Entity is an entity that participates in an APM. We'll stop there. Or it's an entity that participates in the payment arrangement with a non-Medicare Payer. So that's important to note, also. The Advanced APM is a payment arrangement or a payment approach that guides or gives added incentive payment to provide high-quality, cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population. Affiliated Practitioner. An Affiliated Practitioner -- and you'll also see Affiliated Practitioner Lists – is the clinician that's identified by unique APM participation that we find on a list, and the list itself is the list of Affiliated Practitioners of an APM Entity that is compiled from a CMS-maintained list. MIPS APM – Most Advanced APMs are also MIPS APMs. So when we get to the Advanced APMs, you'll also note that these policies will then flow to the MIPS APMs, and the reason why we do that is because we want to make sure that eligible clinicians participating in Advanced APMs also have an opportunity to receive some scoring incentive. So if you do not meet sufficient payments or patients through the Advanced APM, in order to qualify or become a qualified APM participant, thereby being excluded from MIPS, the MIPS-eligible clinician will be scored under the MIPS scoring standard, which we call the APM scoring standard, and it's a MIPS APM scoring standard because we give you additional incentives for your APM participation. So, again, it's the APM scoring standard, and it's designed to really give you some additional participation points for your APM participation. Participation List. The list of participants on this list is actually a compiled list similar to the Affiliated List, and the Affiliated List is just a little different because it relates more to the Advanced APM, but we also see you on and participating in the list of participants. For the Qualifying APM Participant, that participant has met or exceeded the relevant QP payment amount of QP patient count, and that threshold is set for the year based on participation for the year in the Advanced APM Entity. So each year you can qualify. So as we talk about Alternative Payment Models, it's a general definition as we described. APMs are approaches for paying for healthcare that incentivize quality and value. I think it's important to note here that the way we came to APMs is through legislation. The four ways to become an APM is through CMS Innovation Center Models. Under the 1115A Social Security Act, anything other than HCIA, which is the Healthcare Innovation Awards, Medicare Shared Savings Program, demonstration under the Healthcare Quality Demonstration Program, or a demonstration required under federal law. The Advanced Alternative Payment Model falls into a subset of APMs. One thing, the APM, again, is an approach that provides incentives, but, also, it can apply as we described earlier to those specific conditions or population, just as any APM can. In addition, the reason why I said Advanced APM is because we're going to offer you additional or significant opportunities for eligible clinicians to participate to receive some form of bonus, but there's also significant participation at the highest level of APM participation. So, for an Advanced APM to be an Advanced APM, one, you have to meet or basically be a part of an organization that requires CEHRT, which is the Certified EHR Technology, and we also hold APM Participants to the ACO Participant accountable for CEHRT required use, also. So just because you hear the term "APM," it does not exclude ACOs. It provides payment for covered professional services based on quality measures comparable to those of MIPS. That's important to note, also, because we do, as you transition out of an Advanced APM, if you don't meet the threshold, we will be looking at the measures that are comparable to MIPS, and that's at the Quality

Performance category. In addition, the final piece is it's either a medical home model explained under a CMS Innovation Center Authority, and, currently, there are no models that have been expanded, or requires participants to bear more than a nominal amount of financial risk. So as we move into a medical home model that is an APM, there are three main buckets here. The first one is participants included must be Primary Care Practices or Multispecialty Practices that include Primary Care Physicians and Practitioners and offer Primary Care Services. It also must be an empanelment of each patient to a primary-care clinician and at least four of the following additional elements -- plan, coordination of chronic and preventative care, patient access and continuity of care, risk-stratified care management, coordination of care across the medical neighborhood, patient and caregiver engagement, shared decision-making, or a payment arrangement in addition to or substituting for fee-for-service. And we're on Slide 39, and we're moving to the next slide, 40. My apologies there for those that didn't get the slide numbers. So, Slide 40, we're looking at Advanced APMs, and Advanced APMs in Year 2, I'm going to list off those Advanced APMs. One is the Bundled Payments for Care Improvement, what we call BPCI Advanced, and what you'll find there is that this doesn't open until October of 2018, but you will not be eligible for an Advanced APM Participation, which means you can achieve QP status or be eligible to be scored under the APM scoring standard for MIPS until Performance Year 2019. The second model is the Comprehensive ESRD Care Model, which we call CEC, and that's the Two-Sided Risk is also an Advanced APM. The Comprehensive Primary Care Plus Model, and that's CPC+, that's an Advanced APM. Medicare Accountable Care Organization, or ACO Track 1+ Model. Next Gen ACO Model. Shared Savings Program Track 2. Shared Savings Program Track 3. Oncology Care Model, and that's the Two-Sided Risk. We also call that OCM. Or the Comprehensive Care for Joint Replacement, CJR, payment Model, and that's Track 1, and that includes the CEHRT. Next slide, please. On Slide 41, you'll note that there's been no major change to the policies as it relates to APMs under the Advanced APM category. Those participants, in order to achieve Qualifying APM participation to achieve the 5% APM incentive payment for a year and be excluded from MIPS still must meet or exceed the thresholds for payments and patients. The only change has been, beginning in 2019, the threshold may be reached by a combination of Medicare and other non-Medicare payer arrangements, such as private payers and Medicaid, which we will get to. So that's a great transition now. Next slide to 42. On Slide 42, we just have a header here that says "All-Payer Combination Option & Other Payer Advanced APMs." So we go to the next slide, we're going to get into the All-Payer Combination option definition. The MACRA statute created two pathways to allow eligible clinicians to become QPs. The first option is the Medicare Option. That is available for all performance years. Eligible clinicians achieve QP status exclusively based on participation in Advanced APMs with Medicare fee-for-service. Currently, that is how clinicians will become QPs. Starting and it being available in Performance Year 2019, eligible clinicians may achieve QP status based on a combination of participation and Advanced APMs within the Medicare fee-for-service -- that's the Medicare option -- and Other Payer Advanced APMs offered by other payers. So when you combine the two, the "and" conjunction, it becomes All-Payer Combination Option. So you have the Medicare option, along with the Other Payer Advanced APMs. Next slide. So the All-Payer Combination Option. So the All-Payer Combination Option is, along with the Medicare Option, one of two pathways through which eligible clinicians can become a QP for a year. QP Determinations under the All-Payer Combination Option will be based on an eligible clinician's participation, as previously stated, in both the Advanced APMs, the Medicare, and Other Payer Advanced APMs. QP

Determinations are conducted sequentially. So what does that mean? It means that we will start looking at, first, your Medicare Option, and then we will apply the All-Payer Combination Option. Only clinicians who do not meet the minimum patient count or payment amount that I showed to become QPs under the Medicare Option, but still meet a lower threshold to participate in the All-Payer Combination Option, are able to request a QP determination under the All-Payer Combination. So if you meet the minimum, you can then add to that. The All-Payer Combination Option is available beginning in the 2019 QP Performance Period. So the All-Payer Combination Option, as we look at the policy, Other Payer Advanced APMs are non-Medicare Payment Arrangements that meet -- and this is next slide, 45 -- that meet criteria that are similar to Advanced APMs. Payer types that may have payment arrangements that qualifies Other Payer Advanced APMs also must be under this list. So that's Title 19, and that's Medicaid, Medicare health plans, including Medicare Advantage, CMS Multi-Payer Models, and other commercial and private payers. Next slide, please. Slide 46. So All-Payer Combination Options. Other Payer Advanced APMs. So as we specifically look at the Other Payer Advanced APMs, they must be similar to, but not identical to and comparable to the Advanced APMs. What does that mean? Requires at least 50% of eligible clinicians to use CEHRT, or the Certified EHR Technology, to document and communicate clinical care information. Second, we must base payments on Quality Measures that are comparable to those used in the MIPS Quality Performance category, and third, either is a Medical Home Model that meets the criteria that is comparable to Medical Home Model explained under the CMS Innovation Center Authority or requires participants to bear more than a nominal amount of financial risk. So very similar to the Advanced APM criteria. Next slide, please. On Slide 47, we'll find a breakdown of what I've just explained. First are the Advanced APMs and the All-Payer Combination Option. How to determine the Other Payer Advanced APMs. First, prior to each QP Performance Period, CMS will make Other Payer Advanced APM determinations based on information voluntarily submitted by payers. Again, it's voluntary that the payer may submit, which we refer to as the Payer Initiated Process, which you will see when we go to the next slide and show timing. This Payer Initiated Process is available for Medicaid, Medicare Advantage, and payers aligning with CMS Multi-Payer Models for Performance Year 2019. We intend to add remaining payer types in future years. APM Entities and eligible clinicians will also have the opportunity to submit information regarding the payment arrangements in which they were participating in the event that the payer has not already done so in the voluntary timeframe, which we refer when the eligible clinician submits, it's called the Eligible Clinician Initiated Process. So the payer submits first in the Payer Initiated Process, and then, second, the eligible clinician can submit. For Medicaid payment arrangements, APM Entities, and eligible clinicians will be able to submit information prior to the relevant QP Performance Period. For all other payment arrangements, APM Entities and eligible clinicians will be able to submit information after the relevant QP Performance Period. Next slide, please. This is Slide 48. So what we see here is the Performance Year 2019 timeline for Other Payer Advanced APM determinations. It is important to note that you will see the Medicaid timeline, and then you will see the CMS Multi-Payer Models timeline. So for the Medicaid timeline, the submission form is available to states at the beginning of the year, and then we go to April of 2018 is the deadline for the state submissions. In September of 2018, the submission form is available for the eligible clinicians, and CMS will post initial lists of Medicaid APMs that's determined. November 2018 is the deadline for the eligible clinicians to submit their information, and in December 2018, we will post a final list of Medicaid APMs. Under the CMS Multi-Payer Models, January 2018, the

submission form is available for Other Payers. In June 2018, the deadline for Other Payer Submissions is available. In September 2018, CMS posts a list of Other Payer Advanced APMs for the Performance Year 2019, and then in August 2019, we will make the submission form available for eligible clinicians. The timeframe's a little different, but the timing of each portion of the form made available may shift, but it's still the same opportunity to submit your data. CMS in December 2019 will update the list of Other Payer Advanced APMs for Performance Year 2019, and this is also the deadline for eligible clinician submission. Next slide, please. So, without going back through the timing here, I think it's important to note on this slide that Medicare Health Plans also have their timeline, and then remaining Other Payer payment arrangements will be made available for January 2018 in which, right now, that's for the Other Payers, and starting in August 2019, the submission form will be available for E.C.s, which we call the Eligible Clinicians. Can we go to the next slide, please? So just to wrap up my portion of Advanced APMs, I want to talk a little bit about MIPS APMs, which ties it all together. Next slide, please. MIPS APMs. MIPS APMs are APMs that meet the following criteria -- APM Entities participate in the APM under an agreement with CMS. APM Entities include one or more MIPS-eligible clinicians on a Participation List, and APM bases payment incentives on performance either at the entity or eligible clinician level on cost/utilization and quality. The APM scoring standard. These are just some examples for you to think about. How does the Low Volume Threshold apply to MIPS-eligible clinicians and MIPS APMs? Well, it applies to MIPS-eligible clinicians participating as part of an APM Entity in a MIPS APM. Also, it will be calculated by CMS at the APM Entity level, and finally, if you are an individual or a group that is below the Low Volume Threshold, but part of a MIPS APM, you are subject to MIPS under the APM scoring standard. Also note that the APM could be an ACO, also. So, two scenarios. The APM entity is required to participate in MIPS if it exceeds a Low Volume Threshold. What does that mean for you? This means that the groups and solo practitioners participating in the APM Entity will need to participate in MIPS for that TIN/NPI. So the organization that billing is assigned to. A second scenario. The APM Entity is exempt from MIPS if it does not exceed the Low Volume Threshold. What does that mean for you? That means that groups and solo practitioners participating in the APM Entity will be exempt from MIPS for that billing organization TIN/NPI if the entire APM Entity does not exceed the Low Volume Threshold. Last two slides here. The next slide, going to go to Slide 53. Just want to share with you the snapshot dates of when we will capture this information. The APM scoring standard offers a special, minimally burdensome way of participating in MIPS for eligible clinicians in APMS who do not meet the requirements to become QPs and are, therefore, subject to MIPS, or eligible clinicians who meet the requirements to become a Partial QP and therefore are able to choose whether to participate in MIPS. To be considered part of the APM Entity for the APM scoring standard, an eligible clinician must be on an APM Participation List on at least one of the below snapshot dates. There are three, with a fourth added. Otherwise, an eligible clinician must report to MIPS under the standard MIPS method. March 31st is the first snapshot, and that's January 1st through March 31st, June 30th, and this is March 31st, or April 1st through June 30th, July 1st through August 31st, and then we will take an additional snapshot, and this is for full TIN APMs on December 31st specifically to see if you have joined Medicare Shared Savings Program. And finally, the APM's standard weighting has changed. In Year 2, we're aligning the weighting across all MIPS APMs and assess all MIPS APMs on quality. So, the new policy will be 50% for Quality, 0% for Cost, 20% for P.I. (?

Mm-hmm.

...for P.I., and that's for Promoting Interoperability. I know it's a new term. I get excited with new terms. And then 30%, finally, for our Improvement Activities. I'm going to hand it over to Adam Richards, and thank you.

All right. Well, thank you so much, Corey and Molly, for going through all this information. We know this is a lot of information, so, of course, we will post the slides, and there will also be a recording that will be available in the coming weeks. You can always go back and take a look, and, of course, if you do have any questions, we do have the Quality Payment Program Service Center, as well as our no-cost technical assistance available to help answer some of those questions. We'll talk about that in just a minute. I do want to advance on to the next slide. So we're on Slide 56. And I just want to talk very briefly about the participation status and looking up your participation status for 2018. So we did decide to move to a web-based Look-up Tool for Year 2, for 2018, rather than sending out paper letters like we did last year, really, to make it easier for clinicians to obtain their MIPS eligibility status and allow clinicians to check using their mobile devices or their desk-top computers instead of having to wait for that letter to arrive in the mail. So, to look up your status right now for Year 2 for MIPS, you'll visit qpp.cms.gov and look for the screen that we have in front of you. If you go to the MIPS tab and drop down and just click on "Participation Status," it will bring you to this site where you'll enter in your individual National Provider Identifier Number, and you'll get the status of your eligibility for Year 2 of the program. Now, we have a very special guest on today, actually, because this is kind of breaking news hot off the press. I think this was just rolled out a few hours ago, actually. So I do want to introduce Jean Moody-Williams, our Deputy Director here at the Center for Clinical Standards and Quality to talk a little bit about that rollout. So, Jean, are you with us?

I sure am, Adam, and thanks a lot, and thanks to all the presenters, actually, today and for all the participants on the call, and -- well, thank you, period, for your helping us achieve a successful submission period for Year 1. Now, of course, you've been working through issues for Year 2 on today's call, getting a clear understanding on some things that may have been a question and questions we've gathered along the way, and as you've been listening throughout the call, you can tell that we are listening to you and that we continue to try to be responsive to the questions that you have, the policy recommendations that you have, and so forth, and, just as an example, the news that I wanted to share today is that we clearly heard from you on a number of occasions that we needed to improve the Look-up Tool so that a person with a TIN doesn't have to look up each NPI within that TIN one at a time, and we heard that fairly repeatedly, and so I'm happy to announce today that the QPP website now offers 2018 MIPS clinician eligibility data at the group level. So, effective immediately, when you get off this call, it will be available, but you can now log into CMS to the QPP website, qpp.cms.gov, to check your group's 2018 eligibility for the Merit-based Incentive Payment System. After you log into the feature -- and it is in the authenticated site, so you would have to use your EIDM credentials. You would browse through the Taxpayer Identification Number, the TIN affiliated with your group, and then you'll be able to click into a detailed screen to see the eligibility status of every clinician based on their National Provider Identifier, NPI, and you can find out whether they need to participate during the 2018 performance year for MIPS. Now, when you go in,

there'll be all the kind of caveats or disclaimers as far as what's included and what's not. So I'm not going to go into that on this call. I just wanted to let you know that we've heard you, and we've tried to accommodate you and continue to keep your comments coming, and to the extent that we can, obviously we have to prioritize requests. We will try and make it happen. You will receive a listserv message probably before the end of the day that will give you these instructions, so no need to worry about how to go in, but it's fairly simple to do so. So, again, thank you all for joining, and I'm going to turn it back to Adam.

Great. Thanks so much, Jean, and thank you for joining us. I know we did just roll this out, so we did ask you to be here as a special guest to really announce this for us, and for the participants on the line today, this is a great reason to stick around until the end because you never know when we're going to surprise you with rollouts and special announcements. So, from here on out, make sure you're on and stick with us through the end. But I do -- Within our last 15 or so minutes, because I do want to spend some time answering some questions, but I do want to run us all through just checking eligibility, checking participation status. We don't have the screenshots right now because this is such a new rollout for the TIN-level lookup, but we can at least step through, checking participation status at the individual level. So, on Slide 56, as I mentioned, you'll just drop your NPI number into the open field, and then check "All years." If we go on to the next slide, once you enter in your NPI, you will see one of two screens, really, but we wanted to flag this one for you, because if you see that you are included, if you see that green checkmark "Included in MIPS," you do need to submit data for each associated TIN where you are included at the individual level. So I think this is good practice if you see that checkmark, that "Included in MIPS," to keep on scrolling. Of course, I will say that even if you see an exempt status there, keep on scrolling anyway, because there's always good information within this tool. So if we move on to the next slide, Slide 58, these are a few scenarios, a few cases that you may see once you start scrolling down. As I mentioned earlier, keep on scrolling. So, I won't go through all of these, but we wanted to just give you a flavor of really what you may see in the Look-up Tool. So you could see that exempt status where you're exempt across the board, both individually and as a group. You could see where you are exempt at the individual level, but you may be included at the group level, and if your group does opt to participate, then you would be included with that group, and we also have the scenario where you are included both at the individual and group level, and you want to focus, certainly, on reporting data at that individual level if you do, if your practice doesn't opt to report as a group, but, again, these are just some scenarios of what you may see in the tool. And if we jump on to the next slide... We covered the MIPS component, but there's also the APM component. So right now, the Look-up Tool for 2018 has MIPS eligibility data only. We are working fast and furiously to update the Look-up Tool to include APM Participant status, as well as Predictive Qualifying APM Participant status, that QP status that Corey mentioned earlier. Again, the tool right now does not reflect that 2018 APM information. We are targeting a late spring release of the information to include that in the Look-up Tool. So you will use one Look-up Tool to search for all of your information. Of course, if you're interested in reviewing any of your previous-year data, we still have that option on the link that we've provided onscreen just in case you're curious, but, again, we will be rolling out that APM and predictive QP status information a little later in the spring. With that, we'll move on to the next slide. I'm going to talk very, very quickly here about some of our help and support options. So if go

to Slide 61, please. So I think if you've joined us before, you've probably seen this infographic. None of our help and support options have changed for 2018. We still have -- As you can see in the bottom right-hand corner, we still have all of our technical support available. So, as I mentioned earlier, that includes the Quality Payment Program Service Center. For those who are in models, Alternative Payment Models and Advanced Alternative Payment Models, we do have the Innovation Center's Learning Systems for your model-specific support, but we also have, what I like to call, the on-the-ground networks. So these are groups who are out working with clinicians right now to help them through the 2018 requirements. We have Small and Underserved Rural Support Initiative, which is very focused on Small Practices, those with 15 or fewer eligible clinicians. We have, for larger practices, our Quality Innovation Networks and Quality Improvement Organization -- so any practice over 16 or more clinicians. And then, of course, for those practices and those clinicians who are interested in practice transformation and ultimately moving toward an Alternative Payment Model or an Advanced Alternative Payment Model, we do have the Transforming Clinical Practice Initiative where you can enroll with a Practice Transformation Network. You'll get MIPS-specific support, but you'll also learn about making that transition from MIPS into APMs. It is a good opportunity for those who are interested in making that jump and are ready to do so. So, again, all of this help and support is absolutely free to clinicians who are included in the program. So we certainly recommend reaching out to any of these organizations. If you have questions, you can contact our Service Center, and they will get you the help that you need as soon as possible. So with that, I believe we are going to jump into our next slide, which will be our Q&A portion of this discussion. So I'm going to turn it over to the moderator quickly just to kind of give you the instructions on how you can dial in, and then we'll get started.

At this time, if you would like to ask an audio question, please press Star 1 on your telephone keypad. Again, that is Star 1.

Okay. So, do we have anyone dialed in? I know we just wanted to give folks a few minutes to dial in. We see there's a lot of questions in the Q&A. I know we do have some of our subject-matter experts working through those questions right now. So, please, please, please, if we don't get to your question, we're going to try as best we can. There's a lot of questions coming in. We're doing our best to work through the Q&A right now. We do want to open up the phone line for callers, though. So, do we have anyone on the line?

You do have a question from the line of Kim Sweet.

Hi, Kim.

Hello, everyone, and thank you for taking my call. My question is in regards to the participation status screen. We have noticed with a number of our clients that the address is incorrect on that screen, yet it will be correct in the NPI, as well as in Pay Codes, and I was wondering what do our clients do to get it fixed, or does it matter to get it fixed on this NPI?

Yeah, absolutely. That's a great question. So, our recommendation is to reach out to the Service Center. The Service Center can open up a ticket with our different teams that are working on these products, and we can take a look, see what we can do on our end.

Thank you.

Sure. Okay, we'll take our next caller.

Your next question comes from the line of Sharon Mercelina.

Hi. Thank you very much for the webinar today. My question is, I put in the participation status, and it states there are no 2018 participation details available for this NPI. Is there a registration piece missing? Is there something that needs to be done?

So. This is Molly. So, what that typically means is that we don't have that NPI information on record. So, it's either that the NPI that is being entered is being mis-keyed, where you could be inadvertently mistyping some of the numbers, or that we don't have any record of that elsewhere within our system within PECOS. If you know with certainty that you're entering the NPI correctly, and that this NPI does have an enrollment within our PECOS System and has Medicare billing, I would recommend that you reach out to our Service Center, and we can work with you through that in more detail, but typically that's the reason why that message would come up.

Okay. Because they don't show 2017, either, and we participated. We sent everything in. We did everything with MIPS that we had to for the entire year. Now, who would I call? I'm sorry. I didn't get that number.

Oh, sure. It's the Service Center, and their information is on... Sorry.

That's on Slide 61. We do have our Service Center number and e-mail address listed. So if you do contact them, they'll be able to help you through any challenges.

Right. I didn't get the phone number because we didn't get the slide yet.

It's on Slide 61 under the Technical Support box, but I'll read it to you.

Please.

It's 866-288-8292, or you can contact them via e-mail at qpp@cms.hhs.gov. Thank you.

Thank you so much.

Thank you.

And your next question comes from the line of Christina Gaston.

Hello. This is Christina. I was going to ask about the Hospital-Based slide in the MIPS Year 2 2018. I don't remember what slide it was, but I just wanted to double-check because I know last year if they were a Hospital-Based clinician, but they were part of a big Tax I.D. that included several non-Hospital-Based clinicians, they would have still needed to submit their data as part of the whole group, right -- as a group submission? I don't know if that changed.

It did not change. The policy's still the same. If they report individually, and they're Hospital-Based, then their Promoting Interoperability performance category would be reweighted to the Quality

category, but if they're part of the group, you would include the data from the hospital-based clinicians in the group submission.

All right. Perfect. Thank you.

Your next question comes from the line of Lisa Sagwitz.

Hi. Earlier in the presentation, there was mention of an NPI Number 1 and an NPI Number 2, and I'm not familiar with those terms. Can you explain that a little more, please?

Sure. This is Molly. And if you have the slides, it's referenced on Slide 33. So, NPI 1, that typically refers to the individual rendering NPI. Type 2 NPIs are typically a group-level NPI. So it typically would refer to a hospital, a home health agency, a lab, or a DME supplier.

Thank you.

Your next question comes from the line of Terri Dittermaier.

Thank you. I have some nurse practitioners who work in a Hospital-Based outpatient clinic who have assigned their billing to the hospital system, and they are not capturing any of the MIPS data necessary, so they have been assuming the penalty. If a nurse practitioner leaves that health system two years later, does the penalty follow their NPI or will it circle back to the hospital system?

Sure. That's a great question. This is Molly. So, we do have policies in place that in a scenario where a clinician leaves the practice, and then they move to another practice, that their payment-adjustment status follows them. So we will have processes in place to have that occur. I hope that helps answer your question.

So even though it's beyond their control that nothing's being captured now, they will actually assume that penalty two years later when the hospital was the one that was not capturing the data?

So, if for the first year of MIPS, the Nurse Practitioners Organization decided not to participate, they decided to assume the negative 4% penalty, when we go to apply the payment adjustment in 2019, we will first look for the specific TIN/NPI combination that we would have anticipated to receive data on during our first performance period. If we don't see any billing for that specific TIN/NPI combination, then we would apply the adjustment to another TIN that the NPI would be associated with.

Okay. Thank you.

Thank you.

And we're going to take one more question, and then we're going to wrap up today because we are getting close to time. So we'll take that last question now, please.

Your next question comes from the line of Doug Linko.

Hey. Good afternoon, everybody. This isn't really, necessarily, a question. It's more of a suggestion. So, first and foremost, I want to say thank you

to whoever listened to and made it possible for us to look everything up by group-level TIN. It's incredibly helpful. However, I will add a caveat to that request or kind of an addendum to it is, can you make it possible to download the -- connect the clinicians off the website to your TIN? And the reason I say that is when we went through this process last year, there was a big disparagement between what was showing up on the website and what was truly showing up on our ACO Participation List, and I could get my hands on the ACO Participation List, but I couldn't get a list of what was being reflected on the portal, and there's no way to download it. So I had to copy/paste all 1,500 providers into an Excel spreadsheet and delete out all the unnecessary information.

Yeah, sure. This is Molly. So, great question, and thank you for the positive feedback. It just goes to show that we are listening to your comments that you give to us, so definitely please continue to share them with us. For your second comment on the enhancement of a download or export functionality, great point. I actually asked the team that same question earlier today. It's something that we are working on rolling out, so we do hope to have that available in the near future. So just stay tuned for more information on when that will be available. In the meantime, two work-arounds that you can do are within the authenticated experience, you can, essentially, print from the screen there, or you could copy and paste and put it into whatever format is more user-friendly for you. Not ideal, I know, but there's one option for you there. The other approach that you could take is if you have the technical capabilities to do this, we do have that information available through our Eligibility API, and we have more information on our various APIs at our qpp.cms.gov site under -- I think it's under a "Developers" tab on that website. So that's another way where you could automatically receive all of the group-level information for your NPI. I hope that helps. Thank you.

It does. Thank you.

Great. Thank you so much. So we are at time. I want to thank our presenters for certainly walking us through the Year 2 Participation Criteria. Thank you for all of our subject-matter experts answering questions in the Q&A chat, but, most importantly, I also want to thank each of you for joining us today. Your questions and your feedback, like the discussion we just had, helps us to continue to improve the program, and for that, we are very grateful. So please remember to sign up for the Quality Payment Program listserv for future events and webinars, as well as some of our updates on new resources or even our releases of new resources. It really is a great system of communication for staying up to date on the Quality Payment Program. And with that said, I want to thank each of you again, and we'll talk to you again soon. Thank you.

Ladies and gentlemen, that does conclude today's conference call. You may now disconnect.